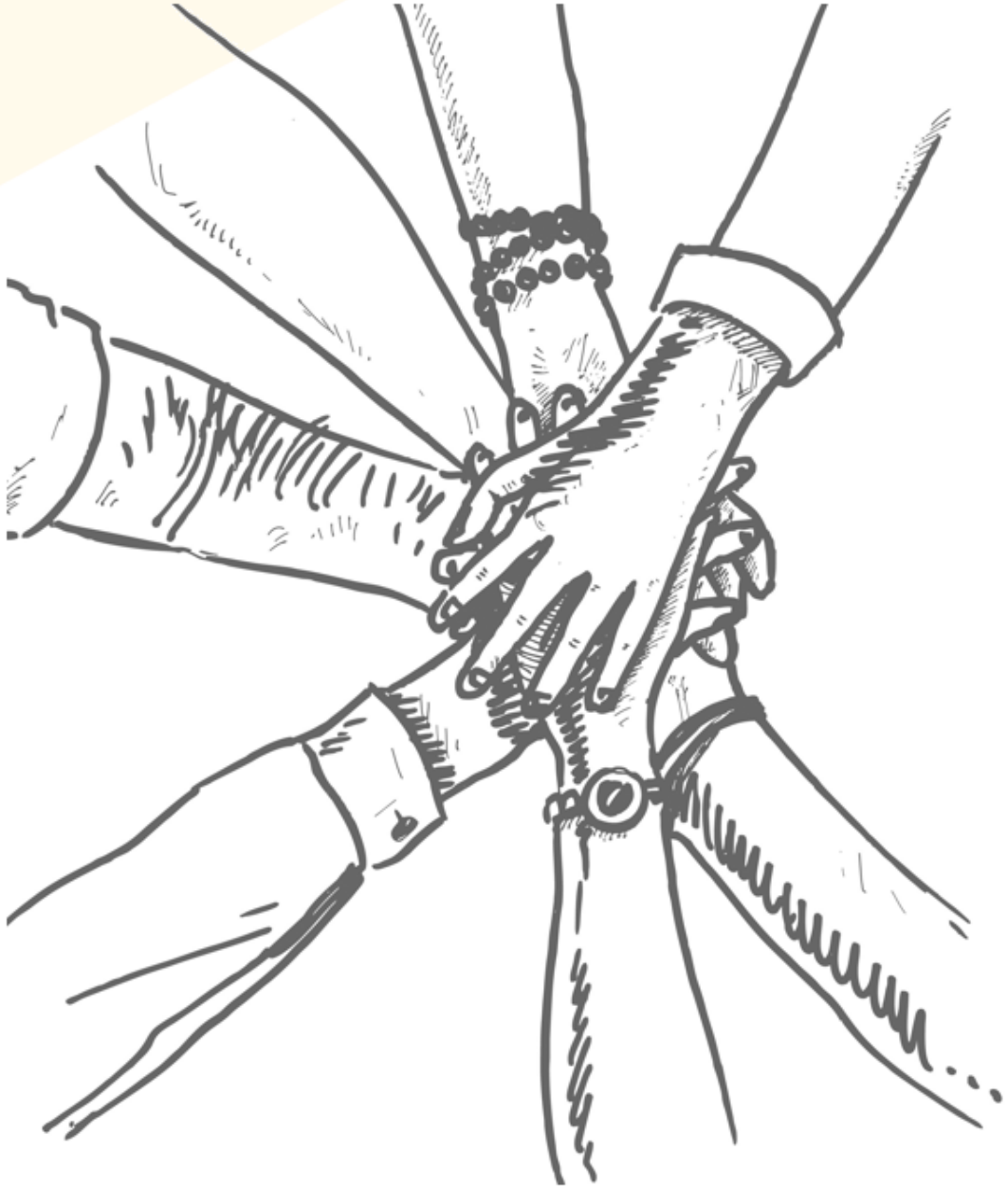

Safeguarding Partnership Annual Report 2022/2023

Safeguarding Children in Stockport

Safeguarding Adults in Stockport

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Purpose of the Report

Working Together 2018, requires the Children's Safeguarding Partnership to publish a report on an annual basis. The Care Act 2014[1] makes the same statutory requirement of the Safeguarding Adult Partnership[2].

The purpose of this report is to set out what safeguarding partners have done between April 2022 and March 2023 because of the arrangements, including child safeguarding practice reviews, and how effective these arrangements have been in practice.

It contains the following:

- Evidence of the impact of the work of the safeguarding partners and relevant agencies, including training, on outcomes for children, adults and their families from early help to children in care and care leavers
- An analysis of any areas where there has been little or no evidence of progress on agreed priorities
- A record of decisions and actions taken by the partners in the report's period (or planned to be taken) to implement the recommendations of any local and national child safeguarding practice reviews, Safeguarding Adult Reviews, and other research, including any resulting improvements
- Ways in which the partners have sought and utilised feedback from children, adults and families to inform their work and influence service provision
- Work undertaken between April 2022 and March 2023

Our report this year is written against our three strategic priorities of:

1. Neglect and self-neglect
2. Complex Safeguarding
3. Domestic abuse

As a Partnership we will refresh our business plan and strategic priorities from April 2023. Our new priorities for 2023 – 2026 are included at the end of this annual report.

Our vision: is 'working in partnership to support and safeguard the people of Stockport to enable them to live safe, healthy and, where possible, independent lives'.

The vision of the adults and children's safeguarding partnership is translated into a joint action plan through a three year Strategic Plan underpinned by a Business Plan which is reviewed and refreshed annually. The current Strategic Plan (2023-26) was agreed in June 2023. It is based on five priorities:

Improve partnership working and information sharing, effective transitions from childhood to adulthood, understanding complex trauma and assessing risk, working with men and working with adults to manage risk effectively and making safeguarding personal.

How the Partnership works

The Stockport Safeguarding Children Partnership (SSCP) and Stockport Safeguarding Adults Partnership (SSAP) comprises the 3 Statutory Safeguarding Partners (Stockport Council, NHS Greater Manchester and Greater Manchester Police) alongside other agencies across education, housing, health and social care, and the voluntary sector. A full list of SSCP and SSAP member agencies is included at Appendix B.

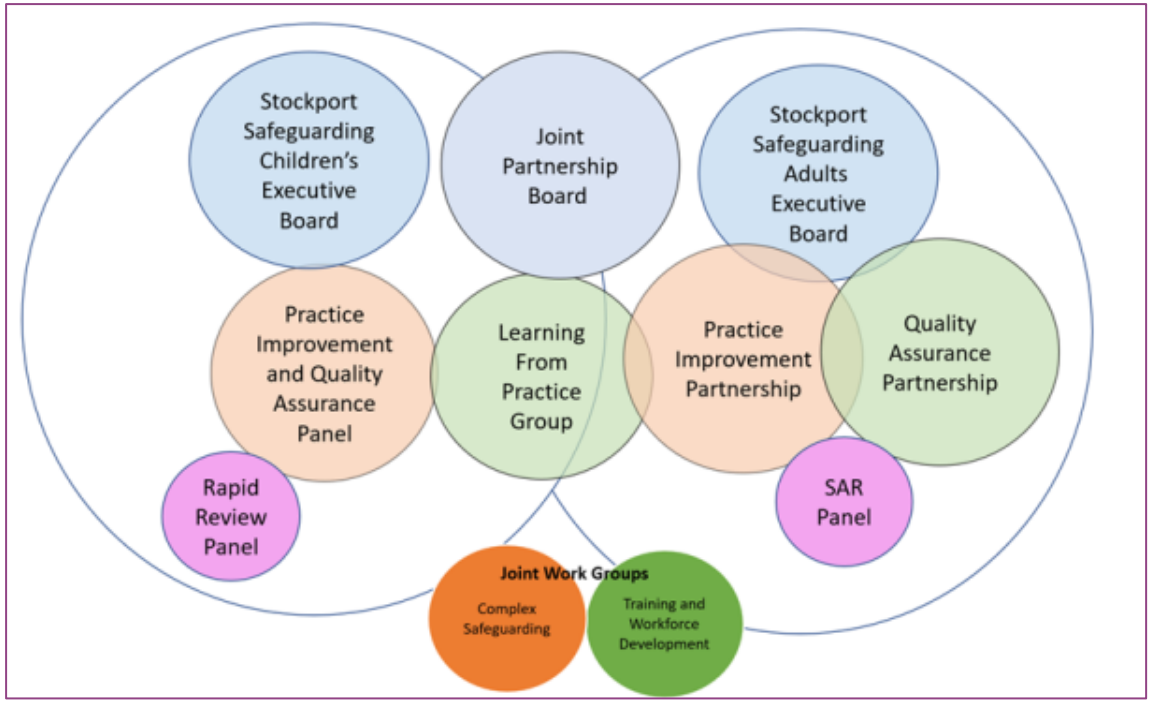
The Partnership comprises of Executive Boards and Sub-Groups. The Children and Adults Partnerships each have an Executive Board as well as a Joint Children & Adults Board. There are Quality Assurance and Practice Improvement Partnerships for both Partnerships. The Partnerships are also supported by two joint working groups; the Complex Safeguarding Group and the Training and Development Group.

The three key safeguarding partners, Stockport Local Authority, NHS Greater Manchester (Integrated Care Board) and Greater Manchester Police, contribute most of the funding for the partnership to operate effectively. The contributions can be found in the appendix.

The SSCP and SSAP Executives are both chaired by the same Independent Chair and Scrutineer, under current arrangements as the scrutiny and challenge that an independent person brings is valued. The Vice-Chair will be one of the three statutory partners nominated each year.

Practice Improvement Partnership
The work of this partnership group is underpinned by a learning and improvement framework, and is responsible for overseeing case reviews; initiating, reviewing and endorsing policy and practice guidance/standards; learning from published inspections, case reviews and research to continuously improve the quality of services and outcomes for children.

Quality Assurance Partnership
The work of this partnership group is to scrutinise and challenge the work of partners by integrating a range of information and is underpinned by a quality assurance framework and dataset. This subgroup is responsible for the moderation of all completed action plans for case reviews that have been overseen by the Practice Improvement Partnership and oversees a programme of multi-agency audit.



Safeguarding Children and Adults Joint Governance

How the Partnership works – continued

Complex Safeguarding
Co-chaired by the Head of Service for social work services and practice improvement, Stockport Family and the Principal Social Worker, Adult Services. Stockport Council. The group develops, implements and monitors the complex safeguarding strategy and action plan to ensure there is a co-ordinated multi-agency response to sexual exploitation, criminal exploitation, missing children and adults, modern day slavery and trafficking.

Training and Workforce Development
Chaired by the Partnership training manager. The group is responsible for ensuring that high-quality, up to date, effective, all age focused, and all age multi-agency training is provided alongside single-agency safeguarding training. The multi-agency trainer will continue to develop the learning hub approach in the next year to ensure learning is embedded routinely for the multi-agency workforce. The dissemination and embedding of learning is available in a separate report, however, the partnership is satisfied and assured that training has continued at pace through a variety of methods during and following the pandemic.

Rapid Review Virtual Panel
This is generally chaired by the Head of Safeguarding and Learning Service and brings together the three safeguarding partners to decide on whether to progress to a rapid review as laid out in Working Together to Safeguard Children 2018. If a case meets the criteria, then a rapid review panel is convened then this is chaired by the Head of Safeguarding and Learning Service and will consider whether a local child safeguarding practice review is to be commissioned.

Learning from Practice Group
This sub-group is chaired by the relevant Safeguarding Partnership Business Manager, and brings together partners in a focused way to review progress against safeguarding review action plans. The work of this group is overseen by the Practice Improvement Partnerships and ensures there are no undue delays in delivering system improvements for the children, adults and families of Stockport.

Domestic Abuse Operations
Chaired by the domestic abuse programme manager, the group brings together agencies from the community, voluntary and statutory sector. The group analyses domestic abuse data from various agencies to identify trends, themes and focus reviewing activities. The group also reviews progress of implementing the Domestic Abuse Act 2021. This group however reports to the domestic abuse partnership board which sits under the Stockport safer

Domestic Abuse Partnership Board
Chaired by Detective Chief Superintendent for the Stockport borough, Greater Manchester Police. The board develops the strategic approach to tackle domestic violence and abuse across Stockport for children, adults and families. Partners work together to deliver on the strategic action plan and identify needs in relation to services and approaches to tackle domestic violence and abuse.

Chair's introduction

This is the second Annual Report to which I have contributed, since taking up my role in October 2021. It has been a privilege to continue to work with both safeguarding partnerships.

In the last year it has been noticeable how many workforce changes have taken place across the key partner organisations in particular. This has an impact on stability and continuity, and a number of leaders have stepped up and across roles to maintain progress of each partnership's work for which we are all grateful.

At our last development day, partners recognised the benefit of relational working, the importance of face-to-face contact in building trust and this has contributed to post-pandemic recovery as the majority of partnership meetings have taken place in person, with greater contribution, support and challenge being evident between all partners.

It has been heartening to see shared learning, collaboration and constructive challenge in discussions between professionals and this led to recent agreement that in our 2023-26 business plans, there are more joint priorities than single ones for the Children and Adult partnerships, recognising that many of the issues that create difficulties for those vulnerable to abuse, neglect and exploitation do not sit in single groups of the population.

Part of my role is to provide and seek independent scrutiny of the work and delivery of each partnership. This has been both acknowledged and welcomed by partners in Stockport where there is openness to learning and an acceptance that a clear line of sight within and between partner organisations is an important route to seeking assurance. This will continue going forward and I am confident that both partnerships will continue to support this approach.

Our vision is to work in partnership to support and safeguard the people of Stockport to enable them to live safe, healthy and, where possible, independent lives

Gail Hopper
Independent Chair and Scrutineer

Chair's introduction continued

Three major challenges facing the partnerships are those of meeting the needs of changing populations, the impact of the cost of living crisis in a context of serious public sector financial pressure and the resulting gaps in capacity to meet local needs

Changing Population

Between 2011 and in 2021, the local population increased by 4.1% to almost 295,000. This is lower than the average Greater Manchester increase of 6.9%. Our local population aged 65+ from 2011 to 2021 (16.2%) increase is in line with the GM average of 16.6%. The child population (up to 15 years) has increased in the borough by 5.2%. The number of people living in borough who identify themselves as other than white British has also increased.

7.6% of the population identify as disabled. This is a fall from 8.9% in 2011. The population of those identifying as white has fallen in Stockport from 92.1 to 87.4, with a comparative increase in residents identifying as Asian, Arab or other. At the time of producing this report, the number of refugees and asylum seeking, residents continues to increase with resulting challenges on suitable housing provision. The partnerships have acknowledged the need increase awareness, understanding and knowledge about how to ensure equality, diversity and inclusion are addressed when safeguarding the vulnerable

Cost of Living

More families and adults of all ages are continuing to struggle as a result of high costs of food, fuel and heating, along with interest rates impacting on mortgage and rental costs. This has led to increasing demands on public services as people make decisions about whether to "heat or eat", with many charities such as food banks lacking the resources to support those in greatest need. Key partners recognise the importance of working together and avoid offloading pressures onto other partners as a result of financial limits.

Capacity

Having identified priorities for both partnerships for the coming years, organisations now face the challenges of balancing increased demands and pressures. I have noted that both partnerships are effective in identifying priorities, but can struggle to deliver consistently to meet the associated objectives. The partnerships acknowledge this and are working together to identify increased monitoring arrangements that will focus on delivering agreed actions. It is also crucial that we have the continued engagement from all partners at both an Executive Board level and at all of our sub-groups.

What do we know about Stockport?

- **18.9%** aged 0-15
- **61.0%** aged 16-64
- **20.1%** aged 65+

294,776 people living in the borough in 2021
(ONS 2021 census)

18.1% Disabled under the Equality Act

76% adult care homes rated Good or Outstanding *(as at March 2023)*
(Data at March 2023 taken from Q4 SSAP dashboard)

38% live in areas of higher than average deprivation
(2020 JSNA)

- **3207** open referrals between April 2022 – March 2023
- **271** Section 47 enquiries initiated
- **54** Graded Care Profile 2 assessments initiated to end March 2023
- **482** children in care
- **245** children with a Child Protection Plan

(Data at March 2023 taken local authority Tableau report)

7.3% Asian
2.6% Mixed
1.6% Other
1.2% Black or Caribbean
(ONS 2021)

451.1 (per 100,000) Alcohol related admissions to hospital *(as at March 2022)*

1800 (per 100,000) Over 65s admitted to hospital due to falls *(as at March 2022)*

87.1% Take up of flu vaccinations in over 65s *(as at March 2022)*

913 accepted referrals into substance misuse treatment services *(START data in SSAP Q4 dashboard)*

37.8% children in year 6 overweight or obese
65.1% Adults overweight or obese
12.8% Adults who smoke

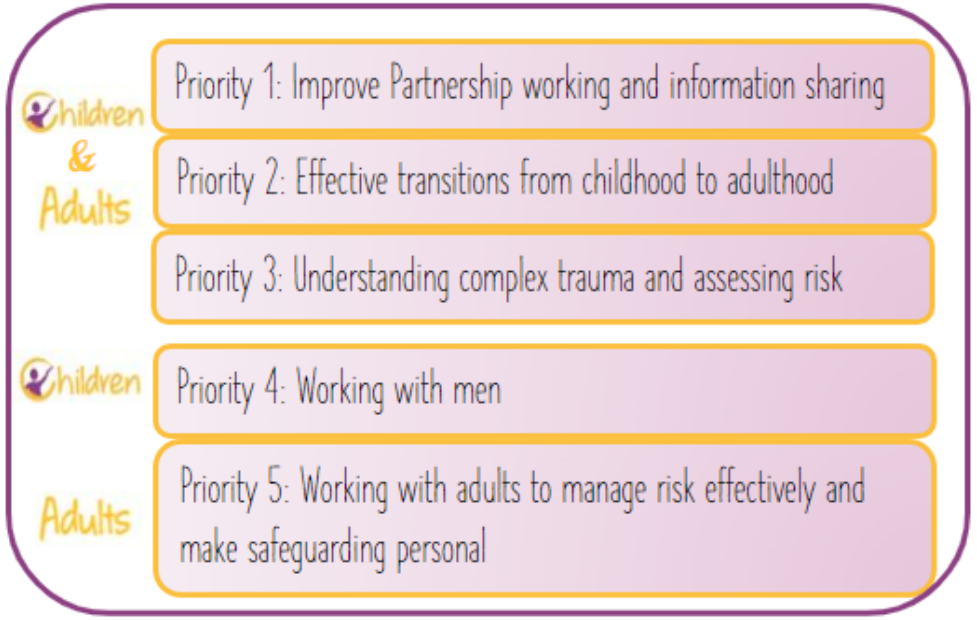
14,500 children with more than one ACE *(2020 JSNA)*

89 Stockport's CLA reported missing during 2022/23 *(Data at March 2023 taken local authority Tableau report)*

All data not referenced taken from https://bigstockportpicture.co.uk/corporate-performance-dashboard/

Strategic Priorities and Thematic Areas

As a wider adult and children's partnership we have agreed several areas that we want to concentrate our efforts on over next three years, our shared priorities for 2023-236 are:



Our agreed thematic areas for 2021 – 22 were:

- To improve frontline practice
- Receive assurance that safeguarding arrangements are embedded in all agencies commissioning strategies and service specifications
- Keep the focus on our most vulnerable children and adults
- Effectively engage with our frontline practitioners, service users, families and/or their representatives

What did we say we would do this year?

Thematic area	What did we achieve?	What else do we need to do?
Complex Safeguarding	In March 2023 we formalised our new working arrangements for the Complex Safeguarding Sub-Group and introduced 3 new working groups to strengthen our work in this area. The new groups have dedicated remits around: • Child exploitation • Transitional safeguarding • Modern day slavery & organised crime We started planning for a learning hub on transitional safeguarding which will be completed in April 2023.	We will complete the outstanding development work on transitional safeguarding learning hub. Delivery of learning circles on Modern Slavery and Human Trafficking will continue. We will continue to support Greater Manchester Police in finalising a local policy and procedure around Cuckooing. We will closely monitor the impact of changes to how this sub-group works to ensure its effectiveness in completing strategic plans
Neglect and Self-neglect	We considered learning from a Safeguarding Adult Review referral which featured self-neglect. Single-agency work has taken place to develop approaches to addressing self-neglect, for example Pennine Care NHS FT's duty system for advice and guidance, and the introduction of their Tiered Risk Management Protocol.	We will review and refresh our Self-Neglect strategy and guidance. We have more to do around understanding and addressing neglect as a Partnership. Our Adults Quality Assurance Partnership will complete multi-agency audit work to identify strengths and areas for development.
Domestic Abuse	We clarified the role and remit of the Safeguarding Partnership in this area as the local Domestic Abuse Partnership become more established and embedded. This has involved closer working with the One Stockport Safety Partnership. We supported delivery of a multi-agency conference in November 2022 which brought together learning from DHRs and SARs.	We will continue to seek assurance from the One Stockport Safety Partnership and share learning from our own assurance activity around domestic abuse.

Priority area: Complex safeguarding

There was an increasing presentation of children experiencing criminal exploitation in the borough. This includes children who have special educational needs and disabilities (SEND). There is a consistent presentation of young adults at our Multi Agency Adults at Risk Panel (MAARS) who have experienced contextual harm.

We said we will:

- Support partners to develop a partnership response for contextual safeguarding.
- We will identify gaps and produce an all age contextual/transitional safeguarding strategy.
- Strengthen the partnership approach to vulnerable 16–25-year-olds

Aspire Complex Safeguarding Service

The Aspire service sits within children's social care and forms a multi-agency team which includes social workers, a school nurse, clinical psychologist and the team is co-located with GMP exploitation officers.

Peer Review

A peer review was completed of the children's complex safeguarding service in 2023 which offered assurance that practice is good. The review consisted of the following;

- 4 young people's records reviewed
- Focus groups held with relevant professionals involved
- Audits based on the 7 complex safeguarding principles
- Written audits provided detailing reflections and recommendations

Strengths

Several strengths were identified in the peer review. Some of which include;

- Clear evidence of strong multi-agency partnership approach.
- Evidence of complex safeguarding workers being persistent in developing a trusted relationship with young people.
- Language was used appropriately and identified young people as victims of exploitation.
- There were examples of the team challenging poor language used by other organisations.
- Good examples of identity, family history, trauma and context being explored.
- Good example of transition planning
- Pen pictures demonstrated a really good insight into the young people
- There were examples of the trusted relationships psychologist being used for case formulations to inform the plan.

Areas for Reflection

- Some assessments were not very detailed of analytical in content
- Supervision wasn't consistently provided or reflective
- Management oversight wasn't always recorded on children's files
- There were examples of missed opportunities for Aspire to become involved at an earlier opportunity with young people
- Some timescales regarding assessments were not clear
- Police disruption activity is not well embedded
- Training and development of staff regarding risk and impact of online exploitation would be beneficial.

Priority area: Complex safeguarding (continued)

In 2022 we launched our Modern Slavery and Human Trafficking Strategy[3] and this year we continued to monitor delivery of the strategy through our Complex Safeguarding Group. This included the continuation of our learning circles focusing on Modern Slavery.

Our Annual Report in 2022 identified that Stockport had lower than average rates of Section 42 enquiries for Modern Slavery (0.4) and Sexual Exploitation (1.8) when compared against the North West and Greater Manchester regions. Comparator safeguarding data at the end of Quarter 4 2022/23 showed that Stockport was closer in Modern Slavery cases to the Greater Manchester and North West averages, but were still lower than comparators for sexual exploitation[4].

Area	Modern Slavery		Sexual Exploitation	
	2021/22	2022/23	2021/22	2022/23
Stockport	0.4	1	1	1.3
Greater Manchester Average	1.1	1.2	3.6	2.3
North West Average	1.3	1.22	3.43	2.8

Concluded S42 enquiries by type per 100,000 at 31st March 2023. Published by NW ADASS

Partnership Reviewing Activity

Work by both Safeguarding Partnerships at the end of 2023 focused on Learning Hub with a focus on complex safeguarding and transitions.

The audit focused on 3 young people, who had been known to the local Multi-Agency Adults At Risk System (MAARS) Panel. The case selection did not have ethnically diverse representation due to the demographics of adults referred into MAARS. The criteria for case selection were young adults who had left Children's Social Care and were known to different services but not necessarily Adult Social Care. We wanted to select cases from MAARS to understand who is referred into that process, and where gaps in the system may be.

Summary of Learning

The learning hub provided an opportunity for all agencies to explore rich learning through both multi-agency case file audits and broader discussions around navigating services in Stockport. The learning gained from the process is summarised below:

- Information systems between agencies and teams don't always support effective and timely information sharing
- Different plans and assessments are not always complementary of one-another, e.g. EHCPs and Phoenix Assessments are not always incorporated into other safeguarding plans
- Broader multi-agency involvement is required to prevent Leaving Care and MAARS being the default lead agency for young adults in crisis
- Understanding of previous trauma is important when considering how to keep young adults safe and supporting them to live independently
- Sharing good practice and understanding multi-agency plans are an important part of ongoing work with young adults

Priority area: Neglect and self-neglect

Cases of self-neglect in Stockport are managed through care management and are not always recorded as Section 42 enquiries. For this reason, benchmarked performance data looks like there are lower levels of self-neglect in Stockport. The average rates of self-neglect across the North West (52.7) has increased significantly compared to the previous year (40.6)[5]. Analysis of national Safeguarding Adult Reviews shows that self-neglect is one of the most prevalent themes in SARs nationally, and this year we have started to see an increase in self-neglect reported to the Partnership with one of the 2 SAR referrals this year featuring self-neglect as a theme.

We have more work to do next year to review and refresh our multi-agency self-neglect strategy and resources to ensure professionals have access to the support and information they need to support adults at risk of, and currently experiencing, self-neglect.

Area	Neglect and Acts Of Omission		Self-neglect	
	2021/22	2022/23	2021/22	2022/23
Stockport	167.7	125.0	12.2	11.0
Greater Manchester Average	137.9	168.9	41.8	44.1
North West Average	156.6	139.7	40.6	52.7

Concluded S42 enquiries by type per 100,000 at 31st March 2023. Published by NW ADASS

An all-age communication strategy was completed and approved by Children's Practice Improvement Partnership in late 2020, this was revised and updated, most recently in 2023. In addition to this private, voluntary and independent (PVI) guidance was completed and shared with the PVI sector.

Training has continued to be offered across the partnership to ensure the Graded Care Profile (GCP) 2 is used by safeguarding agencies in Stockport when neglect is a concern. 45 GCP2 assessments were completed between April 2022 and March 2023. This has reduced by 184% compared to the same period in April 2021 to March 2022 where 128 were completed. The partnership has raised this as a concern with agencies and an audit took place for assurance.

Social Media Campaigns throughout the year continue to raise awareness of neglect and self-neglect, and one Safeguarding Adult Review (SAR) referral was considered for an adult who had experienced self-neglect. Single agency work has taken place to develop approaches to address self-neglect, e.g. Pennine Care NHS Foundation Trust's duty system for advice and guidance, and the introduction of their Tiered Risk Management Protocol[6].

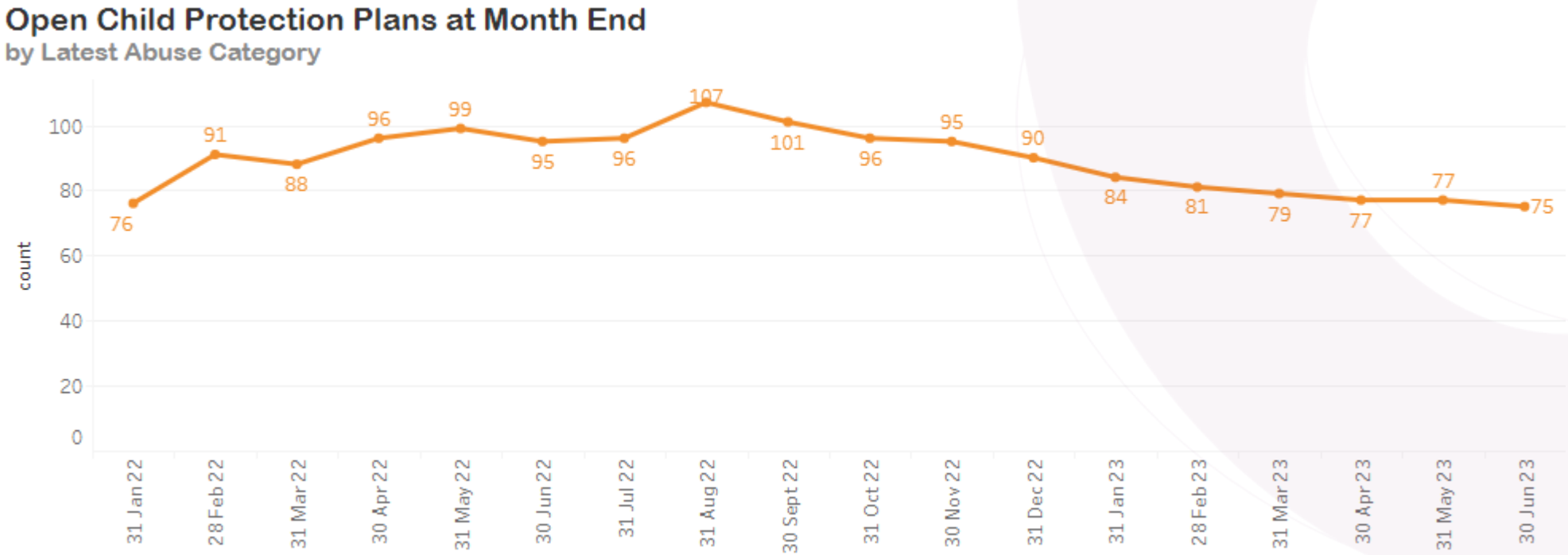
The last year has seen a reduction in referrals made to the Multi Agency Safeguarding and Support Hub (MASSH).

The number of children subject to Child Protections Plans under the category of neglect in April 2022 to March 2023 have increased by 87%. 62 children were subject to a child protection plan under the category of neglect. There were 33 children subject to plans in the same time period between April 2021 and March 2022. the last 12 months has risen.

Audit activity undertaken highlighted that graded care profile assessments are not being consistently used and this could be strengthened.

Priority area: Neglect and self-neglect

In comparison to the last annual report, there has been a 19% decrease of children subject to Child Protection Plans (CPP) under the category of neglect. The below graph demonstrates the decrease in the number of children subject to CPP plans under the category of neglect between April 2022 and March 2023;



Priority area: Domestic Abuse

Whilst domestic abuse is the statutory responsibility of the Domestic Abuse Partnership Board (DAPB), the safeguarding partnership data informs us that we require assurance to ensure appropriate activity is underway to reduce the harms of domestic abuse in our community.

Stockport Domestic Abuse Partnership is committed to preventing and reducing the harm caused by domestic abuse by developing and implementing a sustainable system wide approach to prevention, early intervention, response, and support.

The highest percentage of children on child protection plans are due to emotional abuse caused by the impact of domestic abuse (as seen in the domestic abuse data) There has also been a reduction in the number of MARAC referrals over the past 12 months by 4.8%.

We said we will:

- Have oversight of data to develop quality audits to oversee the effectiveness of agencies' response to domestic violence and abuse
- Support the implementation of the Domestic Abuse Bill across the partnership via the Domestic Abuse Partnership Board (DAPB)
- We will support the domestic abuse operational group to deliver a training programme in relation to domestic violence and abuse

Progress has continued to be made and information on the following pages provides information in relation to the key deliverables.

The Domestic Abuse Bill gained royal assent on 29 April 2021 and is now enshrined in law as the Domestic Abuse Act (DA Act)

In response to the DA Act the safeguarding unit has developed and launched a Domestic Violence and Abuse Strategy 2021 - 2024 which has been published on the website click the link to view the strategy

The strategy is currently being reviewed for April 2024 onwards. identifies five areas of focus;

- Early Intervention and Prevention
- Responding Effectively to Perpetrators
- Working Together
- Appropriate Housing
- Post Abuse Support

Early Intervention

- There has been a decline in Operation Encompass referrals. This has led to an audit being planned later in the year.

Priority area: Domestic Abuse

Caring Dads Programme

Caring Dads is a 17 week group intervention programme which aims to help fathers value their children. It engages fathers, to help them develop more child-centred fathering and to take responsibility for ending their abusive behaviours towards their children and their children's mothers.

There have now been three cohorts of the Caring Dad's programme run in Stockport. Cohort 3 began in August 2022.

There were 63 referrals received in total (since the course began) and 41 fathers have been accepted onto the programme.

24 fathers have successfully completed programme.

Feedback from fathers on the programme;

"made me think more about my partner and her mental health, stopping me having a go about little things."

"Understanding that my thoughts and actions affect my child, not letting my pride get in the way"

"It makes you think, its education, I've learned about the children's emotions. I thought I wouldn't learn anything, but I have. My advice is listen to dads."

Priority area: Domestic Abuse

Themes during 2022-2023

- There continues to be an increase in referrals where high and complex domestic abuse has been a common theme. There has been a notable change in the demographics of families needing support, as well as increased complexities.
- There has been an increase in so-called honour-based violence (HBV) and Forced Marriage referrals, which has required further reflection, development, and training within the partnership. This has led to a task and finish group being set up to develop and strengthen our strategic response to HBV and Forced Marriage.
- Domestic abuse (DA) has been both a current and historic feature within the family's journey. Whilst DA is not the presenting issue for some families, it is later identified as a theme throughout the families' journey. Thematic areas include developing comprehensive plans and including fathers/stepfathers within assessments.
- There has been an increase in cases of child to parent abuse/violence.
- There has been an increase in vulnerable women committing suicide who have experienced domestic abuse.
- There is a high number of repeat MARAC cases in Stockport. Stockport is the second highest borough for repeat cases in Greater Manchester.
- Patterns of vulnerable adults seeking help and then not completing programmes of support offered.
- The cost of living crisis is noted to have contributed towards an increase in domestic abuse incidents.
- The most vulnerable children are aged between 0-5 years old.
- Rise in peer on peer abuse.

Child Safeguarding Practice Reviews and Rapid Reviews

Working Together requires the safeguarding partners to make arrangements to review serious child safeguarding cases, and others where there may be learning, to prevent or reduce the risk of recurrence of similar incidents.

Rapid Review meetings are held within 15 days of the incident coming to the attention of the safeguarding partners. It gathers facts about the case, identifies whether any immediate action is required to secure the child's safety, whether there is immediate learning, and whether a local or national Child Safeguarding Practice Review (L)CSPR is warranted. In the year April 2022 to March 2023 ten Rapid Reviews took place.

Summary of Rapid Reviews:

10 rapid reviews- involving 12 children

2 CSPR's

5 children under 12 months of age

7 children aged 13-17

3 females

9 males

6 children had significant injuries

4 children died

1 child was sexually assaulted

1 child found guilt of murder

Child Safeguarding Practice Reviews and Rapid Reviews Common Themes Identified

Understanding of complex trauma in assessing risk	Information Sharing and Seeking	Working with Men	S.47 processes – roles and responsibilities	Safer Sleep	Harmful Sexual Behaviour
7 cases	6 cases	5 cases	3 cases	2 cases	1 case

Child Safeguarding Practice Reviews (CSPR's)

The partnership has commissioned two child safeguarding practice reviews between April 2022 and March 2023. The reviews are being progressed and will be published in May and July 2023. Upon publication, they will be available on the safeguarding partnership website, which can be accessed by clicking here.

In June 2022 the CSPR Child A was published. The report identified nine learning points for agencies to consider and work on. The learning from practice group formed an action plan based on these learning points, which was completed by October 2022. The work that took place included;

- Training being delivered to designated safeguarding leads in schools.
- Two learning circles delivered to practitioners in relation to learning from this review
- Harmful sexual behaviour task and finish group designed and launched a tool and training to support practitioners in assessing and understanding harmful sexual behaviour.
- Early assurance activity took place in the multiagency safeguarding and support hub to review cases where harmful sexual behaviour was reported as a concern.

Further planned assurance activity will take place in autumn 2023, to ensure that learning has been embedded in practice.

National Child Safeguarding Practice Review Panel

The National Safeguarding Practice Review Panel which oversees and gives advice on Rapid Reviews and Child Safeguarding Practice Reviews. The panel published a National Review in May 2022 titled Child Protection in England, following the review of the deaths of Arthur Labinjo-Hughes and Star Hobson. The Partnership reviewed the report and recommendations made. You can read the report by clicking this link.

It was noted that there were a number of similarities with the learning identified, and recent local learning from rapid reviews and CSPR's.

The National Safeguarding Practice Review Panel also published their national report for 2021-2022 in December 2022 which highlighted 6 key practice themes;

1. Supporting critical thinking and professional challenge through effective leadership and culture
2. The importance of a whole family approach to risk assessment and support
3. Giving central consideration to racial, ethnic and cultural identity and impact on the lived experience of children and families
4. Recognising and responding to the vulnerability of babies
5. Domestic abuse and harm to children – working across services
6. Keeping a focus on risks outside the family

The practice improvement partnership group are exploring the learning from the report and completing a comparison exercise against our own learning.

Review of Specialist Independent Residential Schools

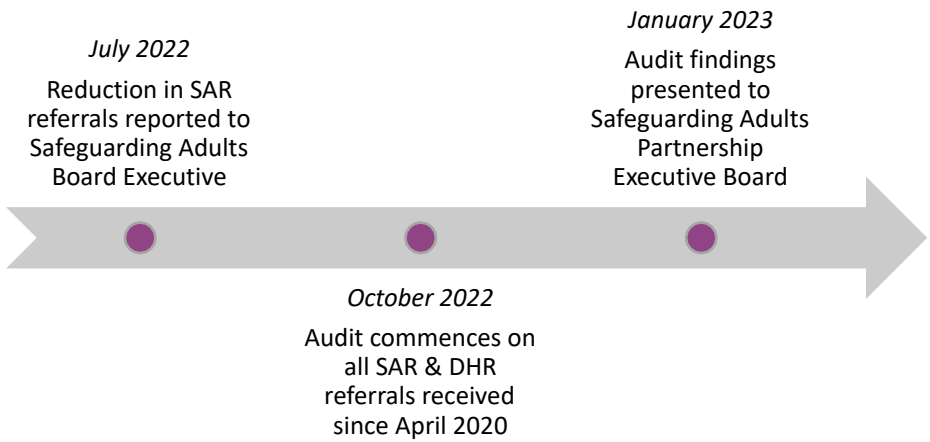
In December 2021 the child safeguarding practice review panel announced that they were going to be undertaking a review of cases at Fullerton House, Wilsic Hall and Wheatley House specialist independent residential schools. This was launched due to concerns in relation to staff members abusing children in their care. Phase one of the report was published in October 2022. You can read this report by clicking here phase two was published in April 2023 and can be read by clicking here

In response to the report and to in line with the advice from the panel to undertake a review of children in these settings; an internal review of children placed in independent residential schools was undertaken. It was reassuring to the partnership that the review found the children to be well cared for, and there were no concerns for their welfare.

THE CHILD
SAFEGUARDING
PRACTICE REVIEW PANEL

Safeguarding Adult Reviews (SARs)

In 2021 we identified that our Safeguarding Adult Review (SAR) activity had decreased, and it was important for us as a Partnership to understand this in more detail. One of our hypotheses was that cases were being referred in to the One Stockport Safety Partnership as Domestic Homicide Reviews instead of SAR referrals to the SSAP. To test this out, our Independent Chair and Scrutineer and Business Manager completed an audit in December 2022 of all SAR and DHR referrals[7].



The audit found strong evidence of multi-agency involvement and engagement at our consideration panel meetings, with both statutory frameworks and criteria well understood by senior leaders across the partnership. Following this we refreshed our SAR training and awareness-raising package and arranged delivery of this to our partners.

We received 2 SAR referrals throughout the year which is a small improvement on the previous year, with main themes identified as transitional safeguarding & exploitation, and self-neglect. The referral rate over the last 5 years has varied as illustrated opposite, with a peak of 18 referrals in 2020/21.

Year	SAR referrals received	Referral outcome		
		Did not meet criteria	Met criteria	Other review commissioned
2018/19	12	5	2	5
2019/20	5	3	1	1
2020/21	18	12	1	5
2021/22	1	1	0	0
2022/23	2	0	0	2

	Referral 1	Referral 2
Who were they?	21-year-old male who had transitioned from Children's Social Care and was both a perpetrator and victim of domestic abuse. He was also at risk of criminal exploitation.	49-year-old male, who was known to multiple agencies and had displayed self-neglecting behaviours.
What did we do?	Partners agreed for this case to be explored as part of a multi-agency learning hub, as it did not meet SAR criteria.	Partners agreed to explore our multi-agency approach to self-neglect through learning from this referral.

We will continue to monitor the rate of SAR referrals, and continue with our awareness raising sessions across all agencies. Work has commenced at a Greater Manchester level to create a shared SAR data set, which is being developed by all 10 SAB Business Managers. Once available, we will use this to better understand our benchmarked position across Greater Manchester.

Our performance: adult safeguarding concerns

Concerns and enquiries

Analysis of multi-agency performance data at the Adults Quality Assurance Partnership this year has told us[8]:

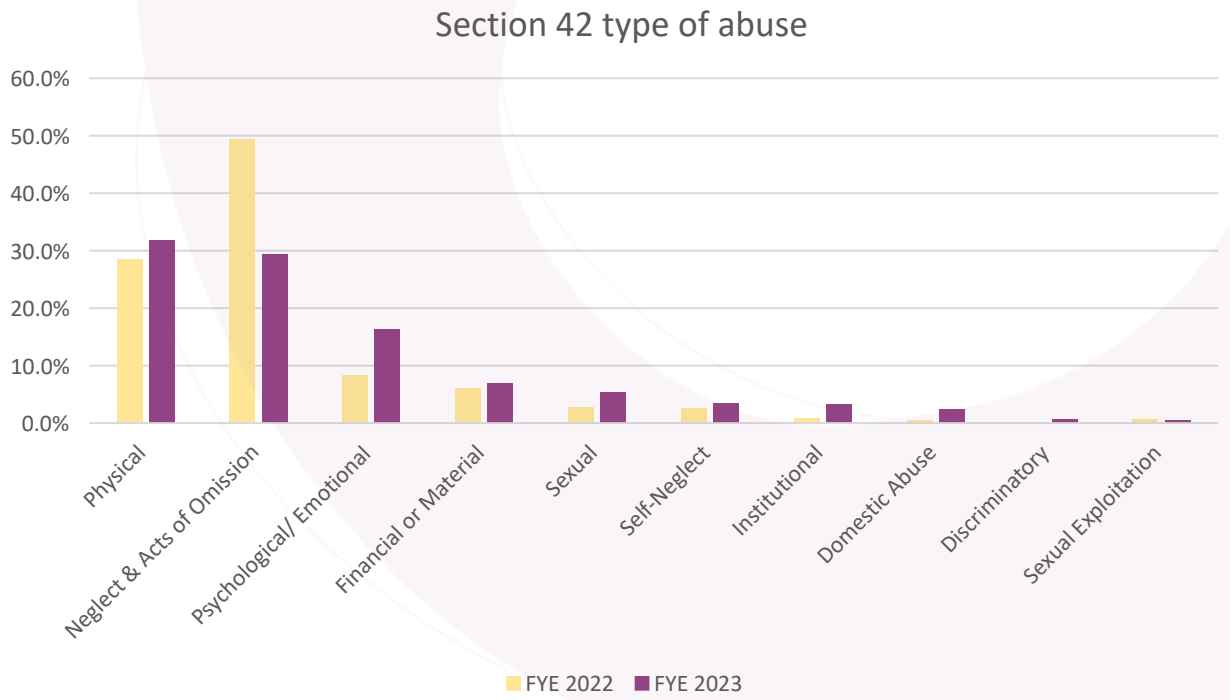
- 43% of all concerns came from Care Homes
- Fewer Section 42 enquiries for self-neglect and neglect and acts of omission compared with Greater Manchester and North West averages
- The proportion of psychological / emotional abuse has almost doubled from 8.4% of all enquiries last year to 16.3% this year
- Neglect and acts of omission has dropped from 49.3% last year to 29.4% this year
- Small increases in institutional abuse (3.3%), domestic abuse (2.4%) and financial abuse (6.9%)

The most prevalent location of abuse and neglect in our data this year was from care homes, which accounted for 43% of all Section 42 enquiries (S42) this year. Through corelating safeguarding data with Harm Levels reports (received from care providers) we have identified an increased proportion of physical abuse S42 reports from care homes which we believe to be *slips trips and falls* that are reported as safeguarding concerns. Work is planned next year to understand this position in more detail.

85.1% of concerns did not progress to enquiry this year, which is an increase from 75.8% in 2021/22. To explore this position the Independent Chair and Scrutineer and Business Manager undertook a visit to the Adult Social Care front door in March 2023[9]. The visit confirmed the large numbers of inappropriate referrals that are received by the local authority. In response, the Partnership has commenced work on a threshold and risk matrix document which will support professionals from all agencies in identifying the level of risk posed by an adult's circumstances, and identifying the most appropriate course of action and referral route in response. This document will be launched in 2023/24.

When looking at the contacts that did not progress to enquiry, 75.2% had no further action taken. A small number of concerns to the Front Door result in information and advice being provided to the referrer (4.1%) and 20.3% are progressed under existing care management.

We have continued to see very low levels of sexual exploitation, discriminatory abuse and domestic abuse in Section 42 enquiries.



Our performance: adult safeguarding concerns

Making Safeguarding Personal (MSP)

We have seen an increase in overall making safeguarding personal (MSP) performance compared to the previous year; this year 72.4% of all adults were asked about their desired MSP outcomes compared with 69.0% in 2021/22. However, we have not seen the reduction in MSP outcomes not being recorded that we would want to see and this will remain a particular area of scrutiny for our Adults Quality Assurance Partnership next year.

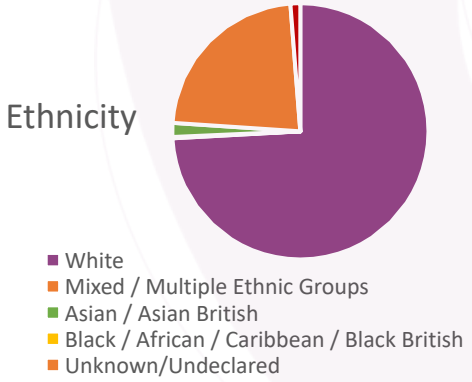
The proportion of MSP outcomes fully achieved has dropped slightly this year from 73.2% in 2021/22 to 59.6%. However, there has been a significant increase in the proportion of outcomes partially achieved this year with the result that overall achieved rate this year (94.0%) is comparable to the previous year (94.9%). This position is slightly lower than the averages across Greater Manchester (65.8% asked and stated) and the North West (69.7% asked and stated) at the end of March 2023[10].

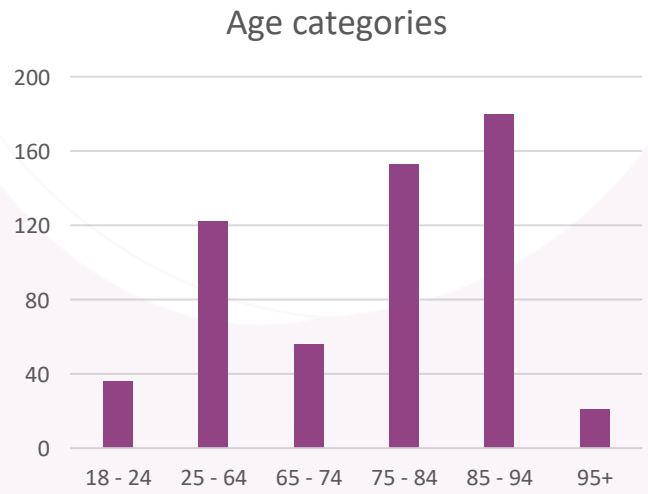
	2022/23	2021/22
Asked and stated	54.0%	42.4%
Asked but not stated	18.4%	26.6%
Not asked	15.8%	17.9%
Don't know	2.9%	3.6%
Not recorded	8.9%	9.0%

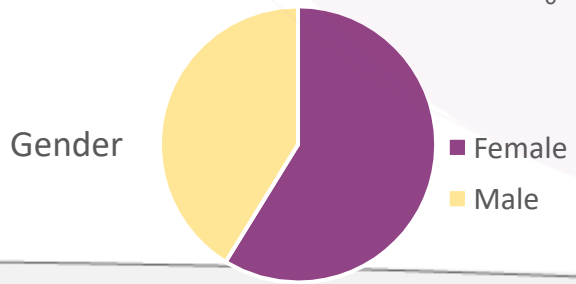
This year we reflected on the demographic data we collect about the adults who receive safeguarding interventions and identified that we could further improve how we fully understand our local population. We do monitor some base demographic information as part of our quarterly dashboard, and this analysis tells us:

- There are more females than males who are subject to Section 42 enquiries
- There are low numbers of 18–24 year olds subject to Section 42 enquiries
- The most common age bracket is 85-94
- 74.1% of all S42 subjects are White British, with 22.7% unknown or undeclared

As we continue to develop our multi-agency performance dashboard, we will ensure that demographic data continues to be collected and analysed at a strategic board level. This will allow our Partnership to develop effective multi-agency strategies to deal with the impact of issues of race, ethnicity, religion, gender and gender orientation, sexual orientation, age, disadvantage and disability on abuse and neglect (including self-neglect).

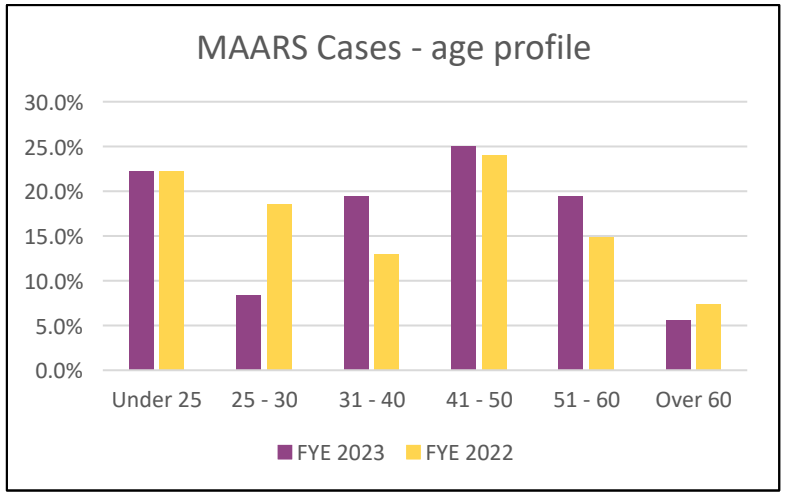






Our performance: Multi-agency adults at risk system

In March 2023 our Joint Children and Adults Executive Board received an update on complex safeguarding cases for individuals aged 18-25 that are presented to our local Multi-Agency Adults At Risk System (MAARS) Panel. As a result of this data report and discussion, the Partnership has commenced a review of MAARS processes which will result in strengthened governance of the process.



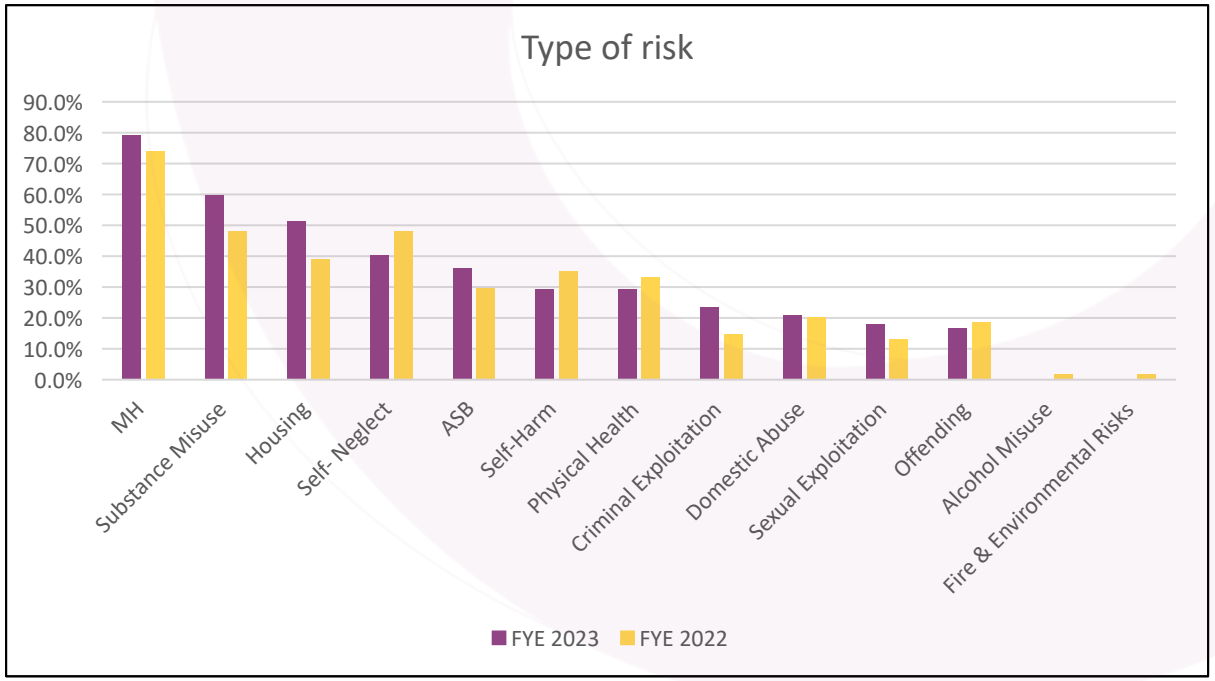
This year we have seen a 33% increase in the number of cases referred into MAARS. There were similar numbers of young adults aged under 25 referred in, with a significant decrease in those aged 25-30.

Since 2020 we have seen an increasing trend in the number of cases coming into the MAARS process[11], and we believe that in part this is due to a strengthened triage process that was introduced in 2021/22, and also because of awareness-raising and staff training that took place throughout this year. The numbers of cases coming through the MAARS process are small and whilst we are seeing an increasing trend, we want to continue to ensure that the right adults are receiving support through this process and other safeguarding pathways and services across the borough.

The most common risk types identified in referrals are:

- Mental health (79.2%)
- Substance misuse (59.7%)
- Housing (51.4%)
- Self-neglect (40.3%)

We have seen an increase in the numbers of sexual exploitation, criminal exploitation and offending cases coming through MAARS, with the number of criminal exploitation cases doubling compared to last year. However, these figures remain comparatively low against other risk areas identified within this cohort.



Learning and development

Last year we said we would prioritise the re-introduction of face-to-face training this year, and we have worked as a Partnership to deliver this ambition. We have continued to prioritise multi-agency workforce development and have delivered both training and awareness raising activities in a variety of different ways this year.

A breakdown of attendance at all sessions throughout this year is shown below. Some of these courses were delivered over a number of sessions.

Courses	Delegates attending
Team around the adult and MAARS	98
Alerter training	407
Chairing safeguarding adults meetings	5
Safeguarding children & adults: MAPPA awareness raising	36
Enquiry officer	40
Hate crime awareness raising	9
Transforming the response to DA in later life	45
Domestic Homicide Review Conference	277

In November 2022 we co-produced and co-delivered a Domestic Homicide Review Conference with the One Stockport Safety Partnership. The conference was attended by over 270 professionals from across the Safeguarding Adults and Children Partnerships and the One Stockport Safety Partnership, and included input from professionals, national research as well as lived experience from adults.

At our Executive Board meeting in December, we started work on a Care Act Self-Assessment which involved input from all Partners and reviewed our effectiveness against statutory obligations introduced by The Care Act. Our timeline for completing this work is by June 2023. Feedback from partners has told us that this is a key piece of work for the Safeguarding Adults Partnership, and it is something that we will look to include in our work plan for coming years to ensure we have ongoing transparency, scrutiny and assurance as a Safeguarding Partnership regarding our purpose and statutory duties.

Our multi-agency training priorities for next year include:

- ✓ Updated adult safeguarding policy and procedure training & awareness-raising
- ✓ All-age hate crime learning circles
- ✓ Joint delivery of modern slavery and human trafficking with police colleagues
- ✓ Damp and mould awareness raising with housing colleagues
- ✓ Understanding exploitation
- ✓ Making Safeguarding Personal
- ✓ Professional curiosity

Co-production

Children in Care Council S.K. Inc.

The S.K. Inc. group have had a busy year and have been involved in a number of workstreams and events, including;

- Involved in the Language That Cares survey.
- Helped to plan a day to gather care-experienced young people's views, alongside a Graffiti Art session.
- Art exhibition at ARC Arts (Hat Works).
- Helped to organise an activity for Celebrating Success.
- Involved in the recruitment of the organisation that has been commissioned to run L!sten (the youth alliance).

Youth Council

The Youth Council have been involved in the development of L!sten (Stockport's Youth Alliance) including the recruitment of the organisation that has been commissioned to run the project.

Feedback from children and families

Feedback from families and children who were spoken to as part of Stockport Family Practice week.

'I like her, she's nice, she listens to me, she doesn't judge'

'really easy to talk to and will get back about any issues or question'

'She has given me chance after chance, she's lovely'

'I can trust them'

'I can speak to her and ask her for help…but I do think I'd like more practical support from her'

'She is easy to talk to and she has done everything she's supposed to do to help me. She's always on time and I think she's excellent'

'She is very caring, down to earth, always available. Supportive and non-judgemental.'

'She lets me rant if I need to'

Children in Care (CIC)

Data

There has been a continued rise in children in care (CIC) seen in the last 12 months of children who remain in the care of the local authority. Data from Q1 2022 demonstrated 446 children were looked after in Stockport compared with Q1 in 2023 where there were 482 children in care.

Stockport continues to have a high number of out of area CIC placed in the borough, however this has reduced in the last 12 months. Local sufficiency of placements has become a focus of the Local Authority who seek to improve this for children in care in the borough.

Remands and Custodial Sentences

During the last year there were a small number of children who received a custodial sentence. All children who are remanded into custody become children in care under the Legal Aid Sentencing and Punishment of Offenders Act 2012. None of the children were children in care before they entered custody.

All Children who receive a custodial sentence are subject to initial planning and regular reviews as per the Youth Justice Board's National Standards. All children who are assessed as a risk to themselves or others will have a plan in place to reduce the risk. There is regular contact between the secure estate and the Youth Justice Service for the period they are in custody

Resettlement starts at the earliest opportunity. Professionals involved from the start, have regular contact with the child in order to build their relationship and plan for release. We have seen this in the cases above where professionals across Stockport Family visit the young person and complete interventions whilst they are in custody, particularly around offending behaviour, exploitation and education provisions

Children in Care (Continued)

Unaccompanied Asylum Seeking Children (UASC)

When unaccompanied asylum seeking children (UASC) arrive in Stockport they are allocated a Social Worker immediately who undertakes the necessary assessments and support to ensure their safety.

In recent months, Stockport has gone from having 16 UASC in their care to 29. Some children have come to Stockport as part of the national scheme and a number have been spontaneous arrivals.

This has placed additional pressure on demand for looked after children and financial pressure on the Local Authority as the Home Office funding doesn't cover the cost of placements and what the children need. There are also now 28 care leavers who were UASC in Stockport who continue to be supported. This has been a challenge for other authorities across the country as more unaccompanied children enter the country.

Sufficiency of Placements

As the number of children in care have increased, this has placed pressure on the availability of local placemats and foster carers.

Sufficiency and quality of placements has now been raised in two CSPR's and a rapid review, this is a priority for the partnership who continue to raise this with the national child safeguarding panel.

There is also a Greater Manchester (GM) sufficiency group exploring how to improve placement availability across GM.

Stockport plans to increase it's number of children's homes in the borough to increase

Improving Outcomes

The Corporate Parenting Group oversees the progress of services for cared for children and focuses on the themes, data trends and key issues for CIC.

Care Leavers

What has changed?

We are conscious that young people who are care experienced can be vulnerable when living independently in the community.

Ring door bells are given to leavers who have their own tenancies to increase their feelings of safety within the home.

Greater Manchester have a digital Wi-Fi offer for free Wi-Fi given to care leavers which is provided by Sky. This offers 24GB of data a month and for those in need of more data, there is a offer has continued for 53 care leavers to have unlimited Wi-Fi for 18 months.

The new accommodation has now opened in Stockport offering 7 independent flats for care leavers to live in. This is accompanied by outreach support. There is a plan to offer further accommodation over the next couple of years to open 20 more flats.

Co-Production

Greater Manchester are currently reviewing care leavers having characteristics and are keen to achieve this for Stockport care leavers.

The local offer continues to be worked out to improve the offer for care leavers from the local authority.

Staying Close projected started in March 2023 to support care leavers with wrap around support when they were living in residential accommodation. The team are currently working with 53 children

The team consists of progression coaches, specialist housing worker, mental health hub (being recruited too) housing worker, lifelong links and EET worker to provide wrap around support to the most vulnerable care leavers.

Partnership auditing activity

The Partnership undertook a number of multi-agency audits throughout the year.

July 2022 Learning Hub event focusing on 'hidden males.' This event brough agencies together from across the partnership to do a deep dive into a number of cases. Learning identified that males aren't always seen or included in interventions from agencies and it is primarily the child's mother who is contacted or worked with.

April 2023 a partnership audit of Neglect cases began. The review looked at 30 children from early help, child in need, child protection and pre-proceedings. The audits highlighted the limited use of the Graded Care Profile 2. The report will be heard at the quality assurance group where actions will be agreed to improve the response to neglect.

In December 2022 we completed an audit of all SAR and DHR referrals.

The audit found a strong understanding of the criteria and process at a senior leadership level, however this was not always fully understood at an operational level. In response, the SSAP Business Manager has developed and rolled out awareness raising and training sessions on SAR criteria, the referral process and *myth-busting* information. The sessions have been made available to all partners.

In September 2022, reviews were undertaken in line with guidance from the national child safeguarding panel of children's advice to undertake a q uality and safety review of children with disabilities and complex health needs placed in residential settings. This review offered assurance to the partnership that children were well cared for in their residential settings and their needs were being met.

In February 2023 we completed an audit of the local MAARS process.

The audit found strengths in how the process facilitates information sharing and joint working. Areas for development in making safeguarding personal outcomes for adults, adult voice, and not labelling adults as "not engaging" but rather considering alternative ways to work with the adult at risk.

April 2022 Learning Hub event focusing on transitions for young adults who were vulnerable to or experiencing exploitation. The event identified a gap in provision for care experienced adults and young adults. The provision for children is strong and agencies need to explore an offer for adults, as this is lacking.

Communications and engagement

Our communications strategy

We know that more women than men are the subjects of safeguarding processes in Stockport (including SARs, Section 42 enquiries and MAARS referrals). For this reason, we want to ensure that our communications and engagement strategy reflects this and we are targeting both women who are in need of support, whilst also encouraging men to seek out any help and support they may need.

This year our social media presence increased with an increase in the number of accounts following our @StockportSAB twitter account and the overall engagement with our social media posts.

Engaging with those with lived experience

We have identified that hearing from, and responding to, the lived experiences of adults in Stockport is an area which we want to improve. For us, this goes beyond social media and awareness raising through our website. This year we introduced ***why are we here*** sections to start each of our Safeguarding Adult Executive Board meetings and have received powerful service-user stories, sometimes in their own words, to act as a powerful reminder of our role and purpose as a Safeguarding Partnership.

Parents Reference Group

The group was established during the pandemic, initially meeting virtually and now face to face or hybrid. The group has five permanent members and are recruiting on a continual basis for more to join in.

All members are parents who have been through the Child Protection (CP) process with their own children, each wanting to use their own experience to shape how the service meets the needs of families going through CP process, and what we do well and what we could do better

The group meet quarterly and so far, they have helped with – designing leaflets for other parents (what is a core group, what is a CP plan/conference); redesigning conference literature; advising us about processes (confidential slot; who attends; timing of reports; pre-consultation with IRO); and giving feedback about the new location of the safeguarding unit (signage; furniture; resources; literature)

The group provides feedback on any wider developments around CP and the service can request their input/feedback on other developments as and when they arise

The creation of a peer mentor scheme has evolved from this group – it is in its infancy; however there have been three parents who have recently been trained as peer mentors and they will begin in their roles soon.

Areas for Improvement

- There is limited feedback from children who are receiving services from safeguarding agencies.
- Agencies within the partnership should improve the feedback gained from children and families. Action needs to be taken in response to gaining regular feedback.
- This is a focus for the partnerships in the next year where assurance will continue to be sought.

What are our priorities for next year?

Multi-agency progress made against business plan delivery is scrutinised at every quarterly meeting of our Executive Board. The current business plan is due for review in 2023, and one of our first strategic priorities will be consultation and engagement exercises with our partners and update our business plan.

We begun joint work with the Safeguarding Children's Partnership in December 2023 looking at our business plan and priorities. This commenced with a multi-agency workshop which was underpinned by multi-agency performance data and a discussion on how all partners felt delivery against our priorities had been successful. From this we identified a number of areas that were explored throughout the early months of 2023 and cross-referenced against learning from child and adult safeguarding reviews. The result was a refreshed draft joint business plan which we presented to our Joint Executive Board in March 2023. This was further refined and developed, and will be launched from June 2023. The new business plan contains more priorities than we have had previously, however all areas are themes which partners feel passionately about and are committed to improving to make the lives of our residents happier, healthier and safer.

Our new priorities are:

<u>Joint children and adults priorities</u>

1. Improve partnership working and information sharing
2. Effective transitions from childhood to adulthood
3. Understanding complex trauma and assessing risk

<u>Safeguarding children priority</u>

4. Working with men

<u>Safeguarding adults priority</u>

5. Working with adults to mange risk effectively and make safeguarding personal

Partnership Funding and Expenditure

The funding arrangements for 2022/23 and forecast for 2023/24 is shown opposite.

	Children's Partnership	Adults' Partnership
Income		
SMBC	138,354	64,889
ICS	32,000	38,000
GMP	13,800	13,800
SNHSFT	4,000	
Probation	1,377	
Education	32,000	
	221,531	**116,689**
Expenditure		
Chair	13,200	13,800
Salaries	187,354	84,189
TASP	1,804	
MRC	3,640	
Mcr Rape	1,320	
ICT	5,456	
Room hire	440	
Quality Assurance		17,000
Sundries	3,000	
	216,214	**116,689**

Key messages for the Partnership

Ensuring we have increased awareness of **equality, diversity and inclusion** issues affecting the people of Stockport. This includes developing robust strategies to address issues as a result of our changing population.

Making sure our **business plan objectives** are delivered through strengthened monitoring arrangements and the right support from our multi-agency governance structure.

Having full and meaningful **attendance and engagement** at all of our Safeguarding Partnership meetings by all partner agencies.

Developing our **scrutiny and assurance of multi-agency performance data** to make sure both Partnerships have the right information to seek assurance and identify appropriate areas for development.

Make sure that we consider **the impact of our work** as a Partnership on the people of Stockport.

Making sure that we **hear the voice and lived experience** of all children, adults and families who access safeguarding services in Stockport.

Maintaining strong and supportive **links with other partnerships**, including the One Stockport Safety Partnership, ensuring we collaborate instead of duplicate in our work.

Appendix A: End notes and references

1. The Care Act 2014: https://www.legislation.gov.uk/ukpga/2014/23/contents/enacted
2. Stockport Safeguarding Adults Partnership (SSAP) is the statutory local multi-agency safeguarding body established under Section 43 of The Care Act 2014.
3. safeguardingadultsinstockport.org.uk/wp-content/uploads/2023/06/Modern-Slavery-Strategy-2021-23.pdf
4. Concluded S42 enquiries by type per 100,000 at 31st March 2023. Published by North West ADASS
5. Concluded S42 enquiries by type per 100,000 at 31st March 2023. Published by North West ADASS
6. TRM Protocol introduced in Oldham and rolled out across the PCFT footprint, designed to address adults with multiple and complex needs including self-neglect
7. SAR and DHR Referrals audit findings reported to Safeguarding Adults Executive Board 14.03.2023
8. 2022/23 year end performance report to SSAP Executive Board 14.06.2023
9. Scrutiny visit to front door report presented to SSAP Executive Board 14.06.2023
10. Data reported in North West ADASS Q4 report 2022/23
11. MAARS data is scrutinised each quarter by the Safeguarding Adults Quality Assurance Partnership

Appendix B: Safeguarding Partnership Members

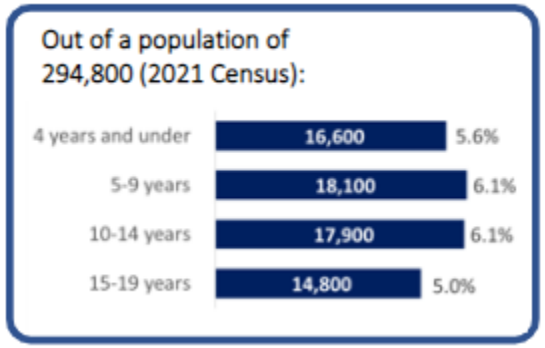
- Stockport Safeguarding Children and Adults Partnerships
- Age UK
- Greater Manchester Fire and Rescue Service
- Greater Manchester Police
- HealthWatch Stockport
- North West Ambulance Service
- Pennine Care NHS Foundation Trust
- Stockport Metropolitan Borough Council
- NHS Greater Manchester
- Stockport NHS Foundation Trust
- Greater Manchester Probation Service

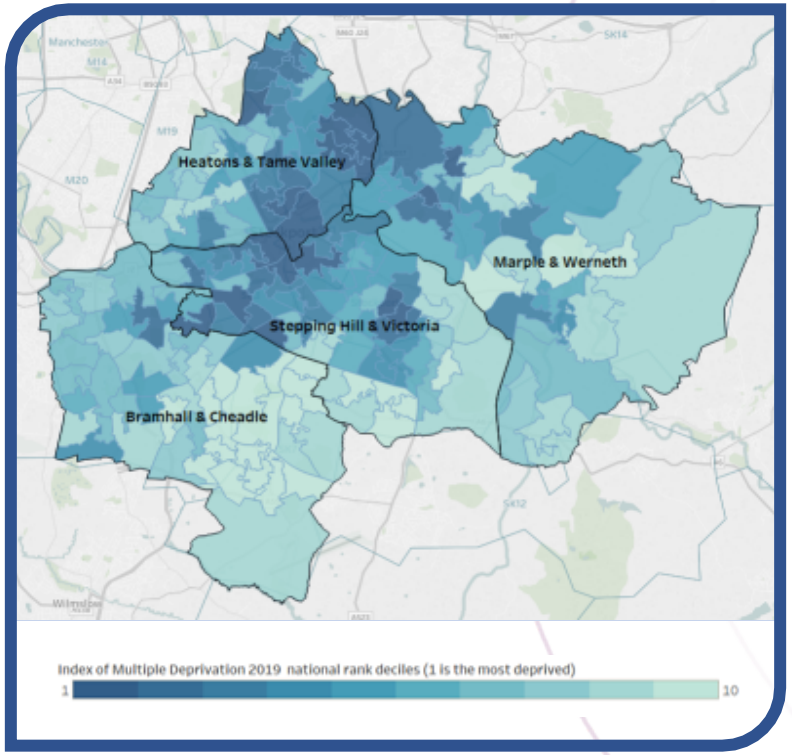
Appendix C: The Town of Stockport

Stockport is very polarised, with pockets of very concentrated deprivation contrasted with large areas where deprivation is relatively low. The 2021 census informs us that out of a population of 294,800, 23% (67,400) are aged 0-19. 11.7% of children and young people (8,500) in Stockport are living in low-income households (JSNA 2018). In Stockport, there are more areas that rank within 1% most deprived nationally than average, Stockport also have the most deprived electoral ward and GP practice within Greater Manchester. Birth rates have grown most rapidly in deprived areas, and population growth generally has been more rapid in these areas, although this may change with planned large scale housing developments in the less deprived areas, but significant growth is still expected in the town centre.

There are currently 127 schools in Stockport:

- 4 maintained nursery schools
- 85 primary schools
- 14 high schools
- 6 special schools
- 3 pupil referral units
- 9 independent schools
- 6 independent special schools.





The town also has several charities and voluntary sector organisations offering services for children and young people, which include Together Trust, Seashell Trust, Signpost Young Carers, Beacon Counselling, Stockport Women's Centre, Stockport without Abuse, Disability Stockport, Parents in Partnership, and Stockport Action for Voluntary Youth.

Appendix C: The Town of Stockport